The Children's House

Confidential

Child Registration Form

Child's Name: _____

Date of Birth: _____ Age: _____

Name of Parent/Carer(1) _____

Relationship to the child: _____

Do you have legal responsibility for the child? _____

Address: _____

Home Contact: _____ Mobile Contact: _____

Email Address: _____

Name of Parent/Carer(2) _____

Relationship to the child: _____

Do you have legal responsibility for the child? _____

Address: _____

Home Contact: _____ Mobile Contact: _____

Email Address: _____

Contact name for emergency use: _____

Relationship to the child: _____

Emergency contact numbers: _____

Doctors address: _____

Doctors contact numbers: _____

Does your child:

- Have any allergies? _____
- Have any dietary requirements? _____
- Need any medication? (If yes please ask a member of staff for the additional form) _____
- Have any special needs or learning difficulties?_____ _____

Is there any events or celebrations that you wish your child not to be included in?

_____

What is your child's first language? _____

Does your child have a religion? _____

Name of class: _____ Year: _____

Name of class teacher: _____

Care Required: Breakfast Club After School Club

Breakfast Club Days Required: Mon Tues Wed Thurs Fri

After School Club Days Required: Mon Tues Wed Thurs Fri

When do you require your child to start? _____

Collection Details:

Name of designated person to collect child (1): _____

Home Contact: _____ Mobile Contact: _____

Relationship to child: _____

Name of designated person to collect child (2): _____

Home Contact: _____ Mobile Contact: _____

Relationship to child: _____

Past Medical History Information

Does your child suffer from, or has ever from any of the following? If you answer yes to any question, please give details in the spaces provided. Thank you.

Asthma	Yes	No
Does your child have an inhaler?	Yes	No
Eczema	Yes	No
Hayfever	Yes	No
Fits/Convulsions	Yes	No
Diabetes	Yes	No
Deafness/Ear Problems	Yes	No
Visual impairment/Difficulties	Yes	No
Colour Blindness	Yes	No
Speech Difficulties	Yes	No
Joint or Bone problems	Yes	No
Weakness in any Limbs	Yes	No
Serious Allergy	Yes	No
Psychological Problems	Yes	No
Learning Difficulties	Yes	No

Please list any operations your child has had giving the name and date:

_____

_____

_____

Immunisation, has your child had the following Immunisations? Please tick the appropriate box.

Disease	Age (Months) 2	3	4	12-15	Age (Years) 3-5
Diphtheria					
Tetanus					
Whooping Cough					
Poliomyelitis					
Hib Vaccines					
Meningitis					
MMR					
BCG					

In the event the designated person is unable to collect your child choose a password that can be used as a security ID. You will have to have to inform your child's collector of this password and inform members of staff of the change.

Without this password your child will not be released.

_____

Parental Consent:

- If my child requires urgent medical attention and it is not possible to contact me, I agree to staff taking my child to hospital.
- I understand that collection my child late will result in a penalty fee.
- In an extreme case of lateness and my child has not been collected after 1 hour, I understand that it is the Managers duty to follow the settings "late collections policy and procedure" and inform Social Services and the care of my child will continue with them.
- I am aware that the setting policies and procedures are available to me at all times and where to find them.

A deposit of £30.00 is required to secure your child's place. This will be refunded to you in your final invoice.

Signature _____

Date _____